The use and impact of inquiries in the NHS

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When things go wrong in the NHS an inquiry is often set up to find how what happened and what can be learnt. Kieran Walshe and Joan Higgins show that since the 1970s inquiries have been resorted to increasingly often to investigate service failures. Such inquiries take various forms, but the pressures seem to be increasing for them to be set up as independent external investigations with full inquisitorial powers

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In the past few years the NHS has been subject to several major inquiries. Such inquiries have been established to investigate poor clinical performance, major service failure, or even criminal misconduct, and they seem to have become an increasingly common political and managerial response to any major problem in the NHS. As a result, the costs, methods and effects of inquiries have begun to be questioned.[1]

This paper explores the use and impact of inquiries in the NHS. It presents an overview of their history and development; describes their purposes and how and why they are set up; discusses the models, methods, and processes that inquiries use; and reviews how their findings and recommendations are used. We conclude with some lessons for policy makers and other stakeholders in the NHS, which might inform the design and conduct of future inquiries.

Summary points

- NHS inquiries take various forms, from small internal inquiries to statutory ones set up by parliament
- Many inquiry reports highlight similar sorts of failures, suggesting that lessons are not always learnt
- Often these failures are organisational and cultural, and the necessary changes are not likely to happen simply because they are prescribed in a report
- Inquiries should conform to the standards of any primarily qualitative method: their biases and generalisability should be more carefully considered

The development of NHS inquiries

We define an inquiry as a retrospective examination of events or circumstances surrounding a service failure or problem, specially established to find out what happened, understand why, and learn from the experiences of those involved. It can be in public or in private; may be independent of those who established it; may have some judicial powers to summon witnesses and gather evidence; and usually reports formally to whoever commissioned it, though its findings may also be of wider interest.

Perhaps the first modern NHS inquiry was commissioned in 1967 to investigate allegations of abuse and ill treatment of vulnerable long stay patients in Ely Hospital, Cardiff.[2] Its report confirmed the substance of the allegations and described problems of poor clinical leadership, an isolated and inward looking culture, inadequate management structures and systems, and inadequate resources, in terms that eerily parallel the findings of the public inquiry into paediatric cardiac surgery at the Bristol Royal Infirmary, published in 2001.[3]

The Ely inquiry was the first of a series of similar inquiries into long stay institutional care in the 1970s and 1980s.[4] There have been many other inquiries in the NHS over the past three decades, some of national importance but many more of largely local interest and scope.

Methods

No comprehensive chronology of health service inquiries is available, but we conducted a search of the Department of Health and King's Fund library bibliographical databases. This retrieved 624 items referring to inquiries from 1912 to 2001. After filtering to remove duplicates and references to inquiries that were not about health care, not in the United Kingdom, and not relevant to our definition of an inquiry, we identified 59 from 1974 to 2002: two in the 1970s; five in the 1980s; and 52 from 1990 to the present. An overview of the characteristics of an illustrative selection of major inquiries is presented in table 1.[5–11]

Trends

Several trends in the use of inquiries in the NHS can be tentatively identified from these data. Firstly, the number and scope of inquiries seem to be increasing (a phenomenon not limited to health care[12]). In the past three years alone there have been five major inquiries—into security and other issues at Ashworth Hospital; pathology services at Alder Hey Hospital; the conduct of gynaecologist Rodney Ledward; paediatric cardiac services at the Bristol Royal Infirmary; and the murders by general practitioner Harold Shipman. Secondly, inquiries seem to have increasingly become concerned with issues to do with the clinical performance of doctors and other health professionals, often in acute care areas. Thirdly, the conduct of inquiries has become more open and more formalised. Problems which in the past might have been dealt with internally, or in private, are now more likely to be examined independently and externally and made public. Fourthly, considerable duplication seems to exist between inquiries, and many events are the sub-

Table 1 An illustrative selection of major inquiries in the NHS from 1969 to 2001

Date	Issues investigated	Inquiry details	Findings and recommendations
1969	Ill treatment, abuse and neglect of long stay patients at Ely Hospital in Cardiff in 1967	Committee of inquiry set up by Welsh Hospital Board, chaired by Geoffrey Howe QC. Conducted in private, evidence given in confidence, no powers to summon witnesses. Held 15 days of hearings, 52 witnesses, transcript of hearings was 1029 pages. Inquiry took about 16 months	Allegations generally found to be well justified, and a result of poor staff training, little leadership, low clinical standards, and resource constraints. Made 44 recommendations including the setting up of an independent hospitals inspectorate[2]
1978	Allegations of poor care, conflict, and breakdown of working relationships at Normansfield Hospital for learning disabilities in Middlesex in mid-1970s	Committee of inquiry set up by the secretary of state under s70 of NHS Act 1946. Had 124 days of hearings, 145 witnesses, transcript of hearings was 14 856 pages. Inquiry took over a year to complete	Allegations generally found to be justified. History of conflict between consultant in subnormality and many other staff, culminating in a strike. Long history of problems not addressed by inadequate senior management. Made recommendations including many staff changes
1986	Deaths from food poisoning of 19 elderly patients at Stanley Royd Hospital, Wakefield in 1984	Public inquiry set up under s84 of NHS Act 1977 chaired by J Hugill QC. Conducted in public, with power to summon witnesses. Had 32 days of hearings, 113 witnesses (and a further 77 who gave written statements only), considered 15 000 pages of documents. Inquiry took 14 months	Problem found to result from failure in basic food hygiene, resulting from poor staff training and supervision. Made 25 recommendations to improve catering management, strengthen inspection, and plan more effectively for infectious disease outbreaks[5]
1992	Deaths and injuries to children at Grantham and Kesteven Hospital in 1991 caused by enrolled nurse Beverley Allitt	Private inquiry commissioned by secretary of state and Trent Regional Health Authority and chaired by Sir Cecil Clothier QC. Conducted in private with no formal powers. Had 35 days of hearings, 94 witnesses, and considered "thousands" of documents. Inquiry took 11 months	Found failings in management and leadership at the hospital, which permitted Allitt's crimes and delayed detection. Made 13 recommendations concerning health screening for clinical staff, the role of coroners, and the monitoring of untoward events[6]
1994	Care and treatment of Christopher Clunis, a mentally ill man who killed Jonathan Zito in a chance encounter in London in December 1992	Private inquiry commissioned by North East Thames and South East Thames regional health authorities and chaired by Jean Ritchie QC. Conducted in private with no formal powers. Held hearings over a 5 month period and received evidence from 143 witnesses. Inquiry took 7 months	Found a "catalogue of failure and missed opportunities" in communication between professionals/agencies, resource shortages, and management of care. Made 82 recommendations for better assessment of patients' needs, care planning and coordination, and interagency liaison[7]
1999	Serious breaches of security and illegal activities at Ashworth High Security Hospital in 1995-6	Public inquiry set up under s84 of NHS Act 1977 chaired by Peter Fallon QC. Conducted in public, with power to summon witnesses. Had 69 days of hearings. Inquiry took 23 months	Allegations of major failings generally supported, and problems of dysfunctional management found. Made 58 recommendations including that Ashworth should close, and major changes in high security/forensic psychiatry services should be made[8]
2000	Removal, retention, and disposal of human tissue and organs from children after death at the Royal Liverpool Children's Hospital (Alder Hey)	Independent confidential inquiry set up under s2 of NHS Act 1977 chaired by Michael Redfern QC. Hearings conducted in confidence. Had 6 weeks of hearings, with 120 witnesses, scrutinised 50 000 pages of documents. Inquiry took 14 months	Serious failings in clinical practice and managerial arrangements found. Made 67 recommendations covering changes to NHS/university structures, coroners' role and function, consent arrangements, and wider systems for dealing with the bereaved[9]
2000	Serious failures in the clinical practice of Rodney Ledward at the South Kent Hospitals NHS Trust 1990-6	Independent confidential inquiry commissioned by the secretary of state and chaired by Jean Ritchie QC. Hearings conducted in confidence with no powers to summon witnesses or evidence. Heard from over 160 patients and many other witnesses. Inquiry took 14 months	Clinical failings documented and confirmed. Made 103 recommendations for changes to quality systems in the NHS and private sector, and consultant appraisal and disciplinary procedures[10]
2001	The management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995	Public inquiry set up under s84 of NHS Act 1977 chaired by Professor Ian Kennedy. Conducted in public with powers to summon witnesses. Had 96 days of hearings, with 577 witnesses (many submitted written statements), examined 900 000 pages of documents including 1800 patients' medical records. Also held 7 seminars. Inquiry took 2 years 9 months	Found serious clinical and organisational failings and concluded that 30-35 more children had died than would have if BRI service had met standards elsewhere. Made 198 recommendations regarding service organisation, leadership, safety, professional competence, public involvement, and the care of children[3]
2001	The conduct of Dr Harold Shipman, a general practitioner in Hyde, Greater Manchester, who was convicted in January 2000 of murdering 15 patients	Public inquiry set up under section 1 of Tribunals of Evidence (Inquiries) Act 1921 chaired by Dame Janet Smith. Conducted in public with powers to summon witnesses. Inquiry started in February 2001	An interim report on the numbers of patients killed and the means used has been published but the final report is not expected until late 2003 or 2004[11]

ject of more than one form of inquiry by different authorities.

Several important recent policy developments have also affected the current and future conduct of NHS inquiries. The Commission for Health Improvement (shortly to become the Commission for Healthcare Audit and Inspection) has been established,[13] with a formal statutory remit to investigate serious instances of failure in the NHS. It has already conducted seven such investigations and has more in progress.[14] The systems for professional self regulation are being reformed, in ways that extend their oversight and make them more accountable to government and the public.[15] Furthermore, new NHS agencies have been set up with responsibility for patient safety issues[16] and for advising NHS organisations on problems of clinical performance.[17]

The purpose and initiation of inquiries

Inquiries are established to serve many different purposes,[18] which can be summarised under six main headings.

- Establishing the facts—providing a full and fair account of what happened, especially in circumstances where the facts are disputed, or the course and causation of events is not clear
- Learning from events—and so helping to prevent their recurrence by synthesising or distilling lessons which can be used to change practice
- Catharsis or therapeutic exposure—providing an opportunity for reconciliation and resolution, by bringing protagonists face to face with each other's perspectives and problems

- Reassurance—rebuilding public confidence after a major failure by showing that the government is making sure it is fully investigated and dealt with
- Accountability, blame, and retribution—holding people and organisations to account, and sometimes indirectly contributing to the assignation of blame and to mechanisms for retribution
- Political considerations—serving a wider political agenda for government either in demonstrating that "something is being done" or in providing leverage for change.

Most major NHS inquiries are formally commissioned by the Department of Health. Statutory inquiries are established by a motion of both houses of parliament under the Tribunals of Inquiry (Evidence) Act 1921 or by the secretary of state under the NHS Act 1977. In the past the NHS Executive and regional health authorities also played an important part in initiating inquiries, and many smaller scale or more local inquiries have been commissioned by health authorities and NHS trusts themselves.

Often inquiries are triggered by an egregious event—something so obviously troubling that it demands some action be taken. However, sustained media attention and well organised lobbying by patient or other groups are also important contributing factors to the initiation of inquiries. Though the decision to set up an inquiry is an acutely political one, Cabinet Office[19 20] and Department of Health[16] guidance identify three main criteria: whether serious harm or loss to patients has occurred; whether the circumstances raise new or poorly understood issues of concern; and whether the events have caused widespread public concern and loss of confidence.

Inquiry methods and processes

Inquiries vary enormously—from a small scale internal investigation in an NHS trust carried out by a panel of executive and non-executive directors with some external advice from, for example, a medical royal college, to a fullscale statutory public inquiry chaired by an eminent lawyer with a panel of experts, equipped with huge legal and other resources, which reports to the secretary of state and to parliament. Broadly, we can identify four main types of NHS inquiry.

- An internal NHS management inquiry, usually commissioned by an NHS trust, health authority, or the NHS Executive and carried out by an NHS panel with a limited degree of independence from the matters being investigated
- A Commission for Health Improvement investigation, which may be initiated by the commission in response to concerns from a wide range of sources or through a request from the Department of Health
- An external private NHS inquiry, usually commissioned by the Department of Health, the NHS Executive, or a regional health authority and carried out by an independent (non-NHS) chair and panel
- A statutory public inquiry, set up by the secretary of state for health or parliament.

Table 2 presents a comparative analysis of these four main models of inquiry, showing an example of each and describing their characteristics. Whichever model is adopted, it seems self evident that an inquiry should aim to be open, fair, and rigorous and to follow procedures which reflect its purpose.

Openness

Only statutory public inquiries are fully open, in the sense that both inquiry proceedings and reports are in the public domain. While private inquiries may have some advantages when dealing with sensitive or delicate matters, there is a growing societal and legal expectation of openness. In the past, the courts have supported the use of private inquiries in the NHS so long as they could be shown to be conducted fairly (Crampton and others *v* Secretary of State for Health (the Allitt Inquiry), 9 July 1993). However, in 2000 families of the victims of Dr Shipman and media organisations were successful in overturning the secretary of state for health's decision to hold the Shipman inquiry in private.[23]

They succeeded because holding the inquiry in private was thought not to be consistent with legitimate expectations based on past practice and precedent in such inquiries and would also breach article 10 of the European Convention on Human Rights, which deals with freedom of expression including the freedom to receive and impart information. Subsequent judgments in other contexts about the right or otherwise to independent official inquiries suggest the law is far from clear.[24 25] It may, however, be difficult to resist future calls for inquiries into deaths or instances of serious harm to patients in the NHS and hard to hold any future major inquiry in private.

Fairness

All the models of inquiry set out above are inquisitorial, which means that the inquiry chair, panel, and legal team frame the issues to be addressed, lead the investigation, call and cross examine witnesses, select documentary evidence to examine, and so on. As a consequence, the responsibility for fairness rests with them.[26] It has been suggested that this inquisitorial approach helps the inquiry to get at the truth while

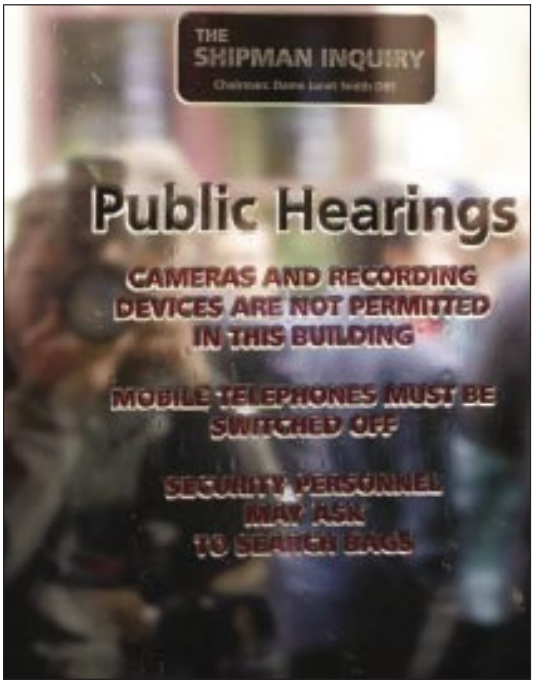

Table 2 A comparison of different models of inquiries

Type of inquiry	Internal NHS management inquiry	Commission for Health Improvement investigation	External private NHS inquiry	Statutory public inquiry
Example	Inquiry into the conduct of research trials in North Staffordshire Hospital NHS Trust (chaired by Professor Rod Griffiths)[21]	Inquiry into abuse and neglect of elderly patients at Garlands Hospital in Cumbria, managed by Lakeland Healthcare NHS Trust[22]	Inquiry into deaths and injuries to children at Grantham and Kesteven Hospital in 1991 caused by enrolled nurse Beverley Allitt (chaired by Sir Cecil Clothier)[6]	Inquiry into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995 (chaired by Professor Ian Kennedy)[3]
Legal authority	None beyond general powers of section 2 of NHS Act 1977	Section 20 of Health Act 1999	None beyond general powers of section 2 of NHS Act 1977	Section 84 of NHS Act 1977 or section 1 of Tribunals of Inquiry (Evidence) Act 1921
Specific legal powers of inquiry	None	Limited statutory powers to require evidence from NHS organisations/staff	None	Wide statutory powers to gather evidence and require witnesses to appear. NHS Act inquiries limited to NHS issues, while Tribunals of Inquiry (Evidence) Act inquiries have no such limits
Inquiry lead and panel	Usually led by a senior NHS manager or clinician, often from another NHS organisation, along with some external assessors/experts	Led by CHI medical director and investigations manager, along with external assessors drawn from other NHS and related organisations	Usually led by a legally qualified and experienced person (QC, judge etc) sitting with external assessors with relevant content knowledge	Generally led by a legally qualified and experienced person (QC, judge etc) usually sitting with external assessors with relevant content knowledge
Secretariat and support	Drawn from the organisation itself —eg, health authority or NHS Executive. Limited resources	Provided by CHI investigations staff and resourced by CHI	Established by inquiry chair. Secretary is usually seconded civil servant or NHS manager. Usually well resourced	Established by inquiry chair. Secretary is usually seconded civil servant. Well resourced
Legal support or expertise	Usually limited or no legal expertise and support	No expertise on inquiry team, but advice provided by Treasury solicitors	Usually have legal expertise on inquiry panel, plus in-house legal staff	Usually have legal expertise on inquiry panel, plus in-house legal staff
Time taken	Variable, from a few days to a few months	Six to nine months	One to two years	Two years or more
Cost	Low—a few thousand pounds	Medium—about £150 000-200 000	Medium to high— from £200 000 upwards	High—millions of pounds
Proceedings	Conducted in private, usually without specific rules or procedures	Conducted in private following CHI's own procedural guidelines	Hearings conducted in private or in public at discretion of inquiry chair	Hearings conducted in public following rules set down by inquiry chair, though may choose to hear some witnesses in closed session
Reporting and publication	Report may or may not be published in part or in full; evidence not published	Evidence taken in private and remains confidential but report is published	Reports to secretary of state. Report then generally published in full, but may not be	Reports to secretary of state and parliament. Full report published, and often most or all evidence
Status of findings and recommendations	Addressed to NHS organisation which commissioned inquiry	Addressed to secretary of state and relevant NHS organisations	Addressed to secretary of state. Department of Health usually issues a formal response	Addressed to secretary of state and parliament. Department of Health issues a formal response

avoiding it becoming a kind of substitute court with an adversarial, confrontational style of interaction and complex legal rules and protocols. It represents a more managed and interventionist style of judicial process which may be more efficient and effective, but is also somewhat at odds with the prevailing approach in the British legal system.[27]

Though the inquisitorial approach seems to serve the investigatory purpose of an inquiry well, and there are established procedures for protecting the interests of affected individuals,[28 29] there are still times when the process of investigation can seem to conflict with the demands of natural justice and due process.[18 30] Inquiries are often chaired by lawyers because of their expertise in this area, but there is a risk that this leads to the subtle juridification of the inquiry process.[3]

Rigour

As table 1 shows, inquiries often involve a huge commitment of resources and undertake an exhaustive review of available evidence. However, sheer scale of investment is no guarantee of methodological rigour. There are no rules or guidelines on how to run an inquiry—each one is different, shaped by its chair and context—and few arrangements exist to carry learning about the inquiry process over from one inquiry to another.

One notable exception is the Commission for Health Improvement, which has begun to develop guidelines for initiating and managing its investigations and whose standing remit to conduct investigations should allow it to build up considerable expertise.

It may be most appropriate to think of inquiries as case studies in organisational failure. There is a well established tradition of case study research in health services,[31] and frameworks developed for evaluating the quality of case studies[32] may help in both designing and reviewing inquiries. The generalisability of case study findings may be challenged, yet inquiries are often ready to extrapolate from one organisation or event and make recommendations for the rest of the NHS. In more general terms, it is not unreasonable to expect that inquiries should conform to the standards expected of any primarily qualitative methodology. The credibility, dependability, and confirmability[33] of inquiry findings should be assessed, and the risk that the biases of inquiry chairs and panels shape their reports needs to be more widely considered.

Inquiry findings, recommendations, and impact

The primary output of most inquiries is a report. Few reports are brief, some are very lengthy, and most make many recommendations, as table 1 shows. The report is formally made to whoever commissioned the inquiry—commonly parliament, the secretary of state for health, the Department of Health, or an NHS organisation. However, since most inquiry reports are published, they have many other audiences as well,

such as other NHS organisations, clinical professionals and managers, politicians, the media, and the general public. Inquiries rely on their credibility and persuasive power to achieve change: they have no formal powers or authority. For this reason, effective communication and dissemination are important.

Yet inquiry reports are often long, comprehensive, densely written, and hard to read. Few people will read them in full, so for most people their main sources of information are executive summaries, digests, and press reports. The inquiry process itself can also have considerable influence, through public hearings, the use of websites, expert seminars, and other means, and in some cases the process may be viewed as just as important as the report itself.

One of the most often cited reasons for undertaking an inquiry, discussed earlier, is to learn lessons for future policy and practice in the NHS. However, in both health and social care many inquiries produce similar findings (see box), despite addressing failures in the quality of care which on the face of it have little in common.[34 35]

The consistency with which inquiries highlight similar causes suggests that their recommendations are either misdirected or not properly implemented. Certainly there are few formal mechanisms for following up the findings and recommendations of inquiries. However, many of the problems identified by inquiries are cultural and demand changes in attitudes, values, beliefs, and behaviours—which are difficult to prescribe in any set of recommendations.

Conclusions

The way that inquiries are used in the NHS is changing. Past models—often using internal NHS panels and conducted in private—are increasingly seen as failing to come up to modern expectations of openness, fairness, and rigour, despite the fact that the products of such inquiries have often been very well regarded.[6] Of the approaches outlined in table 2, two—the public inquiry and the Commission for Health Improvement investigation—seem likely to predominate in future. Inquiries have not been the subject of much research, and there is a pressing need for some evaluation and review of how they work and what they achieve.

The demand for public inquiries is likely to continue to grow unless credible and appropriate alternatives are available. Statutory public inquiries are seen by some as the "gold standard" against which other forms of inquiry should be judged. But it may be more appropriate to think of them as a last resort, to which we turn only when other models of inquiry have failed or are unlikely to be successful.[36] Public inquiries should be used rarely, not simply because they are costly but also because they are slow and unwieldy mechanisms for investigation.

The increasing demand for public inquiries in the NHS probably reflects a lack of public confidence in the alternative models of inquiry and in the quality of care that the NHS provides. The demand for public inquiries in the NHS would probably reduce if credible alternative mechanisms for inquiry were available, and if general levels of public confidence in the NHS were higher.

It is too soon to make a judgment about whether the Commission for Health Improvement will become the predominant body responsible for investigations in the NHS, playing a role akin to that of, for example, the air accident investigations branch of the Department of Transport, Local Government, and the Regions in relation to air crashes. Early indications suggest that it has the opportunity to develop the necessary reputation for independence, integrity, openness, and rigour in its investigations and is well placed to provide a continuity of investigatory expertise which has been lacking in the past. However, some aspects of its current procedures, such as the lack of openness and public scrutiny in the investigation process, will probably need to be revised, if only to meet new legal obligations under the Human Rights Act 1998 and the European Convention on Human Rights.

Common themes of inquiries

Organisational or geographical isolation—which inhibits the transfer of innovation and hinders peer review and constructive critical exchange

Inadequate leadership—lacking vision and unwilling to tackle known problems

System and process failure—in which organisational systems and processes are either not present at all or not working properly

Poor communication—both within the NHS organisation and between it and patients or clients, which means that problems are not picked up

Disempowerment of staff and patients—which means that those who might have raised concerns were discouraged or prevented from doing so

This paper draws upon discussions at a closed seminar hosted by the Nuffield Trust in October 2001, involving a wide range of participants with extensive experience of public and other inquiries in the NHS. We are enormously grateful to all those who took part for their insights and contribution.

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Corrections and clarifications

Why does NICE not recommend laparoscopic herniorraphy?
We wrongly transferred an amendment from the proofs in this article by Roger W Motson (4 May, pp 1092-4), resulting in a nonsensical sentence. The penultimate sentence in the second paragraph of the section "Telling patients the options" should read: " They [laparoscopic surgeons] would further explain that if the patient [with a primary hernia] was unfit for general anaesthesia then they would be limited to open operation under local anaesthetic."

Informed consent for genetic research on blood stored for more than a decade: population based study
In redrafting the line drawing in this article by Birgitta Stegmayr and Kjell Asplund (21 September, pp 634-5), we inadvertently reversed the numbers given for the participants who wanted to be contacted before every new research project in which their blood sample was intended to be used and those who did not want to be contacted (bottom left in figure). The figure should have shown that 202 participants wanted to be contacted, and 1019 did not.

A memorable patient

A crucial statement

One day in early spring Mrs S, a longstanding and familiar patient in the clinic, consulted for cat bites, which had occurred that same morning. She told me (MM) that, without any warning, the cat had jumped on her, scratched her, and bitten her in the right arm. She had already visited the local health authority, which had told her that she didn't need any vaccination. She also told me that our nurse had disinfected and bandaged the wound.

She looked quite bewildered, and when I checked her I noticed that on her right arm she had several deep scratches and numerous bite wounds. It was as if the cat had gone berserk. Knowing that cat wounds can be very deep, I prescribed an antibiotic and sent her home. At the same time, I mentioned that it might be better to get rid of such a ferocious cat, to which she nodded affirmatively.

When she returned three days later I noticed that the wounds were not looking any better, and I changed the treatment. I asked her if she had got rid of the cat, to which she replied, "Not yet." And then she started to explain that it had all been her fault anyway: On the day she'd been bitten a female cat in heat had been howling in the courtyard, and her own cat had got very excited. Wound up by sexual frustration, he had jumped on her when she entered the room.

Gradually her arm got better, and whenever she visited me I would ask if she had got rid of the cat. Yet she would reply, "No, I love him. I just can't get rid of him. He is always so good to me; He has never hurt me. It is not his fault. In fact, it was my fault entirely. If I hadn't disturbed him, he'd never have jumped on me. This is the first time that such a thing has happened, and I'm sure he'll never do it again. He is such a good cat."

To me, her words seemed very strange in the light of the trauma that she had experienced when she first consulted me about the wounds. I said to her: "You know, you relate to this crazy cat exactly as battered women relate to their partners. You use the same words, you express the same guilt feelings, and you're still convinced you love him and believe that he'll never hurt you again."

She then looked at me with a look that was indecipherable.

The next visit was much sooner than expected. She walked into my room, closed the door, sat down, and said, "You know, doctor, when my husband hits me it hurts less than the wounds inflicted by my cat."

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.